STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365625	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Bucyrus Center Fo	1929 Whetstone Street Bucyrus, OH 44820

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, review of the facility investigation, and policy review, the facility failed to ensure Resident #18 was provided adequate supervision to prevent an elopement without staff knowledge. This resulted in Actual harm on 10/22/25 at 2:00 A.M. when Resident #18 was left unattended, eloped from the facility, fell in the parking lot, required Emergency Medical Service (EMS) transport to the hospital, and was diagnosed with a nondisplaced fracture of the nasal bones and a right humerus fracture. This affected one (#18) of three residents reviewed for elopement and falls. The facility census was 71.Review of Resident #18 ' s medical record revealed an admission date of 09/19/22. Diagnoses included unspecified dementia with mood disturbances, schizoaffective disorder bipolar type, delusional disorders, anxiety disorder, major depressive disorder, and insomnia.Review of Resident #18 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had moderately impaired cognition. Resident #18 utilized a walker and wheelchair for mobility, required partial or moderate assistance for sitting to standing and could ambulate 50 feet with supervision or touching assistance, and required substantial or maximal assistance to ambulate 150 feet.Review of Resident #18 ' s admission elopement assessment dated [DATE] revealed Resident #18 was a moderate elopement risk. Factors identified putting Resident #18 at moderate risk for elopement included the diagnosis of dementia, ability to ambulate, propel self in wheelchair, and being seen near windows or exit doors.Review of Resident #18 ' s elopement assessment dated [DATE] revealed Resident #18 was a moderate elopement risk. Factors identified putting Resident #18 at moderate risk for elopement included Resident #18 ' s ability to ambulate, propel self in wheelchair, a diagnosis of dementia, and hallucinations.Review of Resident #18 ' s admission fall risk assessment dated [DATE] revealed Resident #18 was not at risk for falls.Review of Resident 18 ' s fall assessment dated [DATE] revealed Resident #18 was a high fall risk. Risk factors identified were Resident #18 ' s disorientation, required assistance for elimination, balance problems while standing or walking, required use of a walker, use of antidepressants, antihypertensives, antipsychotics, and cathartic drugs, and a neuromuscular/functional decline.Review of Resident #18 ' s care plan dated 10/01/25 revealed Resident #18 was a high fall risk. Interventions included a sign placed in room to remind Resident #18 to ask for assistance when getting up, clipping call light to Resident #18 ' s clothing while in the wheelchair, anti-rollbacks to wheelchair, and a sign placed on the resident ' s walker to remind her to use the walker for ambulation. The care plan contained no interventions related to Resident #18 ' s elopement risk.Review of the facility incident and fall log from 08/01/25 to 10/27/25 revealed Resident #18 suffered a fall with a major injury on 10/22/25.Review of the care plan updated 10/22/25 revealed Resident #18 had eloped and was at risk for elopement. Interventions included for the resident to be checked on frequently, re-direct from exit doors as needed, inform facility staff including the interdisciplinary team and the receptionist of any potential for elopement, staff to report immediately to the nurse any statements by the resident for the need to leave, to go to the bank, home, or work, attempt to determine what the resident wants or is searching for and try to convince the resident there is no need to look outside, and the resident can be outside only with staff one to one supervision and with instruction of the nurse.Review of the facility staffing for the night shift on 10/22/25 revealed the facility had two nurses and five aides scheduled to care for 68 residents. Staff assigned to the Memory Care Unit and Hall 300, located at one end of the building, were Licensed Practical (LPN) #189, and Certified Nursing Assistants (CNA) #144 and #189. At the opposite end of the building, covering Halls 100, 200 and 500 were LPN #122, CNA #102, CNA #146, and CNA #106.Review of the facility investigation dated 10/22/25 beginning at 6:15 A.M. revealed at 12:00 A.M. on 10/22/25 Resident #18 was assisted to the bathroom by CNA #144 at approximately 1:35 A.M. CNA #144, assigned to Hall 300 went to the Memory Care Unit to relieve CNA #189 for a break, leaving LPN #193 on Hall 300. At approximately 2:00 A.M., CNA #144 heard the door alarm from the employee entrance near Hall 300 and when CNA #189 returned at 2:05 A.M. from break, CNA #144 responded to the door alarm and when looking outside, found LPN #193 and CNA #146 attending to Resident #18. An assessment was performed by LPN #193, Resident #18 had no complaints of pain, LPN #193 requested CNA #144 get a wheelchair as LPN #193 and CNA #146 assisted Resident #18 back into the facility. Resident #18, once inside the building, was placed in a wheelchair and covered with a bath blanket. LPN #193 performed a second assessment and Resident #18 was bleeding from her face but denied any pain. Appropriate notifications were made, and Resident #18 remained in the